



ATTENDING DENTIST'S STATEMENT

SIGN BELOW
FOR PREDETERMINATION
OR PAYMENT**

STAPLE X-RAYS TO FORM

P.O. BOX 2059
MECHANICSBURG, PA 17055-2059 • (866) 261-4275

SUBSCRIBER MUST COMPLETE ITEMS 1 THROUGH 15

1. PATIENT NAME		2. RELATIONSHIP TO SUBSCRIBER SELF SPOUSE CHILD OTHER			3. SEX M F		4. IMPORTANT PATIENT BIRTHDATE MO. DAY YEAR		5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL		CITY
6. SUBSCRIBER NAME LAST FIRST MIDDLE INT.		7. IMPORTANT SUBSCRIBER ID. NUMBER									
8. HOME ADDRESS CITY, STATE, ZIP						9. NAME OF GROUP DENTAL PROGRAM AARP Dental Insurance Plan P.O. Box 2059 Mechanicsburg, PA 17055-0759					
10. GROUP NUMBER 1230		IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 13				11. DENTAL PLAN NAME		12. GROUP NUMBER			
13. NAME AND ADDRESS OF CARRIER											

14. DENTIST NAME			22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY			NO	YES	IF YES, ENTER DESCRIPTION AND DATES			
15. MAILING ADDRESS CITY, STATE, ZIP			IS TREATMENT RESULT OF AUTO ACCIDENT?								
16. DENTIST SOC. SEC. NO. OR FED. IDENT. NO.			17. DENTIST LICENSE			18. DENTIST PHONE NO.			23. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		
19. FIRST VISIT DATE CURRENT SERIES			20. PLACE OF TREATMENT OFFICE OTHER			21. RADIOGRAPHS FOR MODELS ENCLOSED? HOW MANY? NO <input type="checkbox"/> YES <input type="checkbox"/>			DATE OF PRIOR PLACEMENT		
									24. IS TREATMENT FOR ORTHODONTICS?		
									IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING		

IDENTIFY MISSING TEETH WITH "X" FACIAL		25. EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.							
		TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER	FEE
	1								
	2								
	3								
	4								
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Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

* PREDETERMINATION OF COST THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS. DENTIST SIGNATURE _____ DATE _____		I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT. PATIENT SIGNATURE _____ DATE _____	TOTAL FEE CHARGED	
** TREATMENT COMPLETED – PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE. DENTIST SIGNATURE _____ DATE _____			PATIENT PAYS	
			DELTA PAYS	
			AMOUNT APPLIED TO DEDUCTIBLE	